STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: August 15, 16, 17, and 18, 2011 Facility number: 000483 Provider number: 15E657 AIM number: 100273470 Survey Team: Janie Faulkner, RN-TC Penny Marlatt, RN Diana Sidell, RN Census bed type: NF 18 Total 18 Census Payor type: Medicaid 17 Other 1 Total 18 Sample: 8 Supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/25/11 by Suzanne Williams, RN	F0000	Supporative documentation will be faxed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0156 SS=C	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation, record review and interview, the facility failed to post the names, addresses and telephone numbers of the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, the Medicaid fraud control unit and a statement as to a resident being able to file a complaint with the State survey and licensure agency. This deficient practice has the potential to affect all 18 residents residing at the facility. Findings include: During the environmental tour of the facility on 8-16-11 between 3:48 p.m. and 4:56 p.m., with the Administrator, an observation was made of a lack of posting of information regarding how to contact the Indiana State Department of Health or the ombudsman's office. In interview with the Administrator at that time, she	F0156	F 156 September 1, 2011, the facility reviewed and revised as necessary: The contact list of names, addresses and telephone numbers of:à ISDH – survey and certification agencyà ISDH-licensure officeà State and local Ombudsmanà The protection and advocacy networkà Medicaid Fraud unitThe written notification of:à Resident Rightsà Facility Rulesà Medicaid Eligibilityà Items and service listing included in their daily rateà Items and services that are NOT covered in their daily rate On August 18, 2011 the facility ordered Resident Rights poster. The ISDH posters were returned to previously posted areas. On August 26, 2011, the facility received and posted the Resident Rights poster for easy access for all residents, visitors, and staff to review at their convenience. September 9,2011, the administrator contacted ISDH to ensure current numbers and addresses listed are correct. Social Services notified all residents verbally and	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the information "used to be near the dining room," and she indicated she was uncertain how long the information had not been posted. Observations conducted on 8-17-11 at 8:00 a.m., 11:40 a.m., 2:45 p.m. and 4:45 p.m. and on 8-18-11 at 9:45 a.m. and 12:15 p.m. indicated a continued lack of posting of this information. The Administrator provided a copy of a document entitled, "Contact Numbers" on 8-18-11 at 2:17 p.m. This document provided contact phone numbers for the facility's Administrator, Director of Nursing, the Social Services Designee, the Business Office, the Indiana State Department of Health and the area Ombudsman. This document did not include addresses or any information regarding complaints or how to file a complaint with ISDH. 3.1-4(j)(3) 3.1-4(l)		in writing of items listed above. Social Services will be responsible to ensure all written notification are discussed during the admission process and information is provided in writing at admission, and then as requested or necessitated, or no less than annually. CQI will review required postings are easily viewable, admission manual contains required information as noted above, new residents are aware of contact list, no less than quarterly.Addendum:The administrator will review required postings are easily viewable, admission manual contains required information as noted above, new residents are aware of contact list, no less than quarterly.	
F0204 SS=D	A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Based on interview and record review, the facility failed to provide clear medication	F0204	F 204 On August 19, 2011, the director of nursing reviewed and	08/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administration instructions which indicated reason for use, and when last received for a resident discharged to home. This affected 1 of 1 closed record reviewed in a sample of 8. (Resident #20) Findings include: Review of "Discharge/Transfer of the Resident Form" provided by the Administrator on 8/17/2011 at 4:55 P.M. and identified as their Policy and Procedure for resident discharge to home, indicated the following: "Purpose 1. To provide safe departure from the facility. 2. To provide sufficient information for after care of the resident....Equipment...8. Discharge summary and post discharge plan of care form(s)....6. a. Include list of medications with instructions in simple terms." Review of the closed record for Resident #20 on 8/17/2011 at 10:45 A.M., included a "Discharge/Leave of Absence Medication Record" for Resident #20, with "Date of Departure: 08-10-11", with the following headings for medications: Medication/Strength; Rx Number; quantity; and Directions for use. "9------8AM Effexor 75 mg -Take one tablet by mouth every day" "4------8AM Potassium CHL 20 meq - Take one tablet by mouth every day"		revised the facility policy and procedure for Discharge Documentation to ensure clear medication administration instructions, the reason for medication use, and when the medication was last administered is included in the discharge to home event. All current residents' medical records were reviewed for initiation of a discharge summary. On August 24, 2011, all licensed nurses were in-serviced on documentation which included, but not limited to discharge summary. The discharging nurse will be responsible to ensure clear medication administration instructions, the reason for medication use, and when the medication was last administered, is included in the discharge to home event. The resident discharging home or the responsible party will be instructed verbally and provided written notification. The director of nursing will be responsible to review all discharge summary documentation, during her next facility visit. CQI will monitor discharge documentation of the discharged residents, quarterly.ADDENDUM:The admin istrator will monitor/review the information from the director of nursing review of discharge documentation on the discharged residents, quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"29-----8AM Hydrochlorothiazide 25 mg -Take one tablet by mouth every day" "26-----8AM Aspirin 81 mg - Take one tablet by mouth every day" "once a wk Actonel 35 mg Take one tablet once a week. Take with a full glass of water and 8AM sit-up 30 min after taking med" Resident or responsible party was informed of the following: (all were checked) ____ Read all directions carefully ____ Give each dose exactly as ordered by prescriber ____ Store all medications out of reach of children ____ Check medication to assure amount sent will last until resident returns to the facility ____ Return unused medications ____ Other: _____ (left blank) Signature of Responsible nurse: (signed by nurse) Date: 8- 10 - 11 Page 1 of 4 Signature of Resident or Responsible Party: (signed by resident) "F/u Appt. c [with] Dr. (name)...." across bottom of page "34---8AM, 8PM Calcium Carb 600 w 400 D - Take one tablet by mouth 2 times			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a day with food." "8 AM, 8PM Atenolol 12.5 mg - Take 1/2 tab by mouth 2 times a day * Hold if diastolic (bottom number of blood pressure is below 60)" "8AM, 8PM Lisinopril 40 mg - Take one tablet by mouth 2 times a day" "11---8P Trazodone 50 mg Take 1/2 tablet by mouth at bedtime." Page 2 of 4 (signed by nurse and resident) "6---8AM, 8PM Diltiazem SR 240 mg - Take one capsule by mouth 2 times a day." "Take house shake after each meal and at bedtime." "8AM, 8PM Check blood pressure twice a day before meds" Page 3 of 4 (signed by nurse and resident) PRN = MEDS AS NEEDED "1---Epipen Jr. 0.15 mg auto - inject - Give as directed if severe allergy reaction to bee sting." "7---Acetaminophen/Codeine #3 (Tylenol #3) - Take one tablet every 6 hours by mouth as needed for pain." "Nitrostat 0.4mg tab SL - Place 1 tab under tongue every 5 min as needed for chest pain x 3 doses. If no relief call doctor" "25---Acetaminophen 325 mg (Tylenol) Take 2 tablets by mouth every 4 hours as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needed for pain." (signed by nurse and resident) Page 4 of 4 Interview with Employee #3/LPN/Charge Nurse/Social Services/Activity Director on 8/18/2011 at 9:32 A.M., indicated, "I documented in the Social Services notes about [Resident #20] finding a doctor, but that's all I documented." "Whoever is here when resident discharges writes the discharge notes in the chart." During an interview with the Director of Nursing on 8/18/2011 at 9:35 A.M., she stated, "The home care nurse called me and had me fax a copy of her MAR [medication administration record], so they could set up meds [medications] for [Resident #20] after she had gone home." During interview with Employee #3/LPN/Charge Nurse/Social Services/Activity Director regarding a Post-Discharge Plan of Care at 9:50 A.M. on 8/18/2011, she pulled a blank form out of drawer and stated, "I'll fill out this form and bring it back to you." 3.1-12(a)(21)			
F0253 SS=D	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the	F0253	The facility will maintain housekeeping and maintenance	08/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure a functioning water faucet was in 1 of 7 restrooms which 1 resident regularly used. This deficient practice potentially adversely affected 1 of 18 residents in the facility. (Resident #9) Findings include: During the environmental tour of the facility on 8-16-11 between 3:48 p.m. and 4:56 p.m., with the Administrator, an observation was made in resident #9's restroom in which the right hand faucet of the sink was missing. The Administrator was observed to attempt to turn the upright metal pipe on the right hand side of the sink without success. At this time. the Administrator indicated she was unsure how long the faucet had been missing. 3.1-19(f)		services necessary tp maintain a sanitary, orderly, and comfortable environment. Maintenace reviewed all resident faucets for functional ability. On August 17, 2011 at 8 AM, the faucet handle was repaced on resident #9's faucet. All staff will be responsible to notify the maintenace department of all repairs needed via maintenace report sheet at the time the repair is observed. The environmental supervisor will be responsible to complete facility inspection tours, no less than weekly. Maintenace staff will be responsible to replace or repair the areas of concerns in a timely manner. CQI will monitor maintenace report sheets, repairs, and maintenace weekly tour findings, no less than quarterly.Addendum: The administraor will monitor maintenace report sheets, repairs, and maintenace weekly tour findings, no less than quarterly.	
F0284 SS=D	When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on interview and record review, the facility failed to ensure a post-discharge plan of care was completed for a resident discharged to home. This affected 1 of 1	F0284	F 284 On August 19, 2011, the director of nursing reviewed and revised the facility policy and procedure for Discharge Documentation to ensure clear	08/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	closed record in a sample of 8. (Resident #20) Findings include: On 8/17/2011 at 10:45 A.M., during the closed record review of Resident #20, a "Discharge/Leave of Absence Medication Record" for Resident #20, with "Date of Departure: 08/10/11", contained the following headings for medications: Medication/Strength; Rx Number; quantity; and Directions for use. "9------8AM Effexor 75 mg -Take one tablet by mouth every day" "4------8AM Potassium CHL 20 meq - Take one tablet by mouth every day" "29-----8AM Hydrochlorothiazide 25 mg - Take one tablet by mouth every day" "26-----8AM Aspirin 81 mg - Take one tablet by mouth every day" "once a week 8AM Actonel 35 mg - Take one tablet once a week. Take with a full glass of water and sit-up 30 minutes after taking med...." There was no Resident Summary Status or a discharge plan of care found during the record review. Review of "Discharge/Transfer of the Resident Form" provided by the Administrator on 8/17/2011 at 4:55 P.M. and identified as their Policy and Procedure for resident discharge to home		medication administration instructions, the reason for medication use, and when the medication was last administered, is included in the discharge to home event. Resident # 20's medical record, along with, all current residents' medical records were reviewed for initiation of a discharge summary. On August 24, 2011, all licensed nurses were in-serviced on documentation which included but not limited to discharge summary completion. Employee #3 was interviewed regarding the response indicated in the ISDH report. Employee #3 states she evidently misunderstood the surveyors request and had under stood them to request a copy of the discharge summary form that is used during a discharge. The discharging nurse will be responsible to ensure clear medication administration instructions, the reason for medication use, and when the medication was last administered, is included in the discharge to home event. The resident discharging home or the responsible party will be instructed verbally and provided written notification. The director of nursing will be responsible to review all discharge summary documentation, during her next facility visit. CQI will monitor discharge documentation of the discharged residents, quarterly. ADDENDUM:The administrator wi	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the following: "Purpose 1. To provide safe departure from the facility. 2. To provide sufficient information for after care of the resident....Equipment....8. Discharge summary and post discharge plan of care form(s)....6. Include list of medications with instructions in simple terms." During an interview with Employee #3/LPN/Charge Nurse/Social Services/Activity Director on 8/18/2011 at 9:32, she indicated, "I documented in the Social Services notes about Resident #20 finding a doctor, but that's all I documented." "Whoever is here when resident discharges writes the discharge note in the chart." "I did call case manager at Family Services to request they set up home care nurse for [Resident #20] prior to discharge." On 8/18/2011 at 9:35 A.M., in an interview with the Director of Nursing she stated, "The home care nurse called me and had me fax a copy of her MAR [medication administration record], so they could set up meds [medications] for [Resident #20] after she had gone home." During interview with Employee #3/LPN/Charge Nurse/Social Services/Activity Director regarding a "Post-Discharge Plan of Care" at 9:50		ll monitor/review the information from the director of nursing review of discharge documentation on the discharged residents, quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.M. on 8/18/2011, she pulled a blank form out of a drawer and stated, "I'll fill this form out and bring it back to you." 3.1-36(a)(3) 3.1-36(b)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions A. Based on observation, interview and record review, the facility failed to follow correct manual dishwashing procedures for a three compartment sink, including correct water temperature, chemical concentration and immersion time. This deficient practice has the potential to adversely affect 16 of 18 residents who were using dietary services during the observation period. B. Based on observation, interview and record review, the facility failed to ensure head coverings were worn by all persons in the dietary area during a meal serving period. This deficient practice has the potential to adversely affect 16 of 18 residents who were using dietary services during the observation period. Findings include:	F0371	F371 On August 16, 2011, the administrator reviewed and revised, as necessitated, the facilities' policy and procedure for Sanitizing the Dishes and Utensils along with the policy and procedure on the use of hair nets. On August 15, 2011, maintenance employee was educated on the facilities policy and procedure for hair covering while in the kitchen. On August 17, 2011, the dietary department was monitored by the administrator and the maintenance employee was visually observed wearing hair covering while making a repair in the dietary area. On August 29, 2011, the facility obtained a new food service supervisor. On September 09, 2011, the dietary department was in-serviced on Sanitizing Dishes and Utensils and the use of Hair nets. The food service supervisor will be responsible to ensure that the facilities' policy and procedures, including but not limited to	09/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A. During a dietary observation on 8-15-11 at 12:48 p.m., Cook #2 indicated sink #1 was filled with hot, soapy water and "a little bit of bleach." Cook #2 indicated she checked the chemical concentration of sink #1 and sink #2 "with the bleach strips to make sure its dark blue." Cook #2 indicated the dark blue color indicated, "200 parts per million of chlorine." The Dietary Manager indicated sink #2 was filled with plain hot water and some bleach. Observation was made of the Dietary Manager removing items that had soaked in sink #2 for at least one minute and then rinse the items under running water. The Dietary Manager indicated he rinsed the items under running water, "as hot as I can stand it." During an interview on 8-16-11 at 1:45 p.m. with the Dietary Manager, he indicated, "After yesterday, we had a chance to look at our policies, so we made a few changes with washing the dishes." The Dietary Manager indicated sink #1 is used with hot water, dishsoap and bleach, sink #2 is used with plain hot water and enough bleach to achieve 200 parts per million of chlorine as verified by test strips and sink #3 is plain hot water in which the washed items are soaked for at least one minute." The Dietary Manager indicated he did not check the temperature of the water in sink #3, but indicated, "if		sanitizing dishes and utensils and hair net use through out her shift. The dietician will be responsible to monitor that facility policies and procedures relating to Dietary are followed during her visits. CQI will monitor sanitizing dishes and utensils, along with staff wearing hair covering during review of dietician consultation reports, no less than quarterly. ADDENDUM: The administrator will monitor that the dietary departments is sanitizing dishes and utensils, along with staff wearing hair covering, by visual viewing staff proformance while in facility, along with review of dietician consultation reports, no less than quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the water seems a little cooler we change it to keep it hot. Should I check the temperature [of the water in sink #3]?" On 8-16-11 at 1:30 p.m., the Administrator provided a copy of a document entitled, "Sanitize Dishes and Utensils." The Administrator indicated this document is currently in effect. The document indicated, "1.) Fill sink #1 with hot soapy water. 2.) Fill sink #2 with hot water. Add 1/2 cup of bleach. 1st rinse sink. 3.) Fill sink #3 with hot water. 2nd rinse. Allow dishes to be completely emerged for 1 minute. 4.) Allow all items to air dry. Do not towel dry." On 8-16-11 at 1:30 p.m., the Administrator provided a copy of a second document entitled, "Sanitize Dishes and Utensils." The Administrator indicated this document is currently in effect. The document indicated, "1. The establishment is using approved sanitizing agents, such as chlorine...3. Operators are using the correct sanitizing concentration and proper test strips in chemical sanitizing dishwashers and 3 compartment sinks...5. 3-compartment sink should have the proper sequencing of wash, rinse and sanitize. Sanitizing water should be 75 degrees Fahrenheit. 6. Wash, rinse and sanitizing water shall be changed as often as necessary to be acceptable clean and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not contaminate the equipment and utensils. 7. Sanitize utensils for 1 (one) minute in a 3-compartment sink. 9. The rinse in a 3-compartment sink can be either submersion or running water in the middle compartment." B. During a dietary observation on 8-15-11 at 12:08 p.m., the Maintenance staff was observed to enter the dietary area from the south door. This staff person was observed to have no head covering in place. This staff person was observed to walk directly behind the dietary staff person plating the lunch meal, continue past her to the refrigerator and obtain a 12- ounce can of cola and again walk directly behind the dietary staff person plating the lunch meal and exit the dietary area via the south exit door. There was no observation of the dietary staff speaking to the Maintenance staff or vice-versa while he was in the dietary area. In interview with the Dietary Manager on 8-16-11 at 2:05 p.m., he indicated the Maintenance staff came into the kitchen area around lunchtime the previous day without any hairnet. He indicated, "We've told him he has to wear a hairnet when he comes in here, but he must have forgot you were here. We've told him we can always hand him anything he needs if he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	doesn't want to wear a hairnet." The Administrator provided a copy of a policy entitled, "Organizational Chart," on 8-16-11 at 1:30 p.m. She indicated this policy is currently in effect. Under Section 7 entitled, "Personnel Policies" and under Section A, "Standards for Dress and Cleanliness," it indicated Dietary employees are to wear "hair nets, covering all of the hair." This policy did not indicate what non-dietary employees should wear for head coverings, nor did it indicate if non-dietary employees should be in the dietary area. 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure all resident medications were properly labeled with the resident's name and were maintaining only unexpired medications. This deficient practice affected 2 residents whose medications were randomly observed (#8, #10) and has the potential	F0431	F 431On August 16, 2011, nursing staff reviewed residents #8 and #10, along with all other current resident's medication to ensure all medication were adequately labeled and with in the correct date range to administer. The administrator contacted the facilities pharmacy regarding the services provided during a	09/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to adversely affect all 18 residents receiving medications in the facility at the time of the observation. Findings include: During the environmental tour of the facility on 8-16-11 between 3:48 p.m. and 4:56 p.m., with the Administrator, an observation was made of a the medication refrigerator in the locked closet near the nurse's station. During the inspection of the refrigerator, a white plastic rectangular container was observed to hold multiple clear plastic bags of labeled medications. Observation of the medications located in the white plastic rectangular container indicated Resident #8 had 1 Biscodyl Suppository with an expiration date of July 2011 and Resident #10 had 5 Promethazine 20 milligram (mg) suppositories with an expiration date of January 2011 and 4 with an expiration date of May 2011. During this same observation, there were loose suppositories observed to be in the bottom of the white plastic rectangular container. These suppositories did not have any labels with them to identify to whom they belonged. The following suppositories were observed: -Biscodyl suppositories: 1 with expiration date of June 2013; 2 with expiration date		monthly review and cart review. On August 31, 2011, the following policies and procedures were reviewed and in-serviced on: * Medication Cart Inspections * Medication ordering and receiving from the pharmacy * Cleaning the med cart * Observation of expiration dates On Sept 7, 2011, a full medication audit was conducted. The pharmacy has provided an attentive schedule to conduct Medication Audits rotating full audits and partial audits, no less than quarterly. The charge nurse, who is responsible for the weekly cleaning of the med cart, will be responsible to review all residents medication is correctly labeled and not expired. The charge nurse receiving the medication as ordered will be responsible to review that medication labels are correct and the medication expiration date is within the time frame of expected use. The director of nursing will be responsible to randomly monitor medication for correct labeling and expiration date, no less than monthly. CQI will review director of nursing audit report along with the pharmacy audit reports quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of September 2013 and 1 with expiration date of October 2013. -Promethazine 20 mg suppositories: 1 with expiration date of October 2011; 1 with expiration date of November 2011; 2 with expiration date of December 2011 and 10 with expiration date of January 2012. In interview with the Administrator during the environmental tour, she indicated all the medications should be checked for expiration dates and all of the medications should have the residents' names on them. She indicated she did not know what to say about the expired medications and the loose medications. On 8-17-11 at 11:50 a.m., the Director of Nursing provided a copy of a document entitled, "Medication Disposition Sheet, dated 8-16-11. The form indicated the Promethazine and Biscodyl suppositories were being returned. The reason for the return was indicated as "expired." She indicated she was returning all of the loose suppositories found on the previous day to the pharmacy for credit or disposal. She indicated since she did not have a particular resident's name to place on the form, she used the name of the facility. 3.1-25(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-25(k)			
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on record review and interview, the facility failed to maintain their	F0441	F 441 The administrator and director of nursing reviewed the	08/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	infection control program in that, following a positive tuberculin test, a resident remained in the facility while further tests to confirm the infection were completed. This affected all 19 residents who were in the facility at that time, and staff and visitors. (Resident #21) B. Based on record review and interview, the facility failed to ensure monthly infection control logs were complete in order to monitor, track and prevent infections in the facility. This had the potential to affect 18 of 18 residents residing in the facility. Findings include: A. Resident #21's closed record was reviewed on 8/18/11 at 12:15 p.m. The record indicated Resident #21 was admitted on 6/2/11 at 7:30 p.m. with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, generalized weakness, and had shortness of air with exertion. A "RECORD OF T.B. TESTS AND IMMUNIZATIONS" indicated a first step tuberculin test was administered on 6/3/11. A Medication administration record indicated the time the initial tuberculin		medical record of resident # 21 along with actions taken by the facility to ensure the safety of all residents and staff related to the suspicious skin test of the resident # 21. The facility followed the policy and procedure of Isolation, the guidance and direction of the resident's attending physician, the Ripley County Health Department Officer, along with the Ripley County Health Department nurse who was in continuous contact with the State Health Department regarding the suspicious skin test. A request for an informal dispute has been submitted relating to this issue. The facility, reviewed and revised, as necessitated, the policy and procedure on monthly infection control log. The infection control logs were reviewed by the director of nursing and CQI team. On August 24, 2011, licensed nurses were in-serviced on complete and accurate Documentation. The charge nurse receiving an order to treat an infection will be responsible to accurately and completely document the information on the infection control log. The director of nursing will monitor the infection control log sheets, monthly. CQI will review infection control program quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	test was given was at midnight. The results documented on the "RECORD OF T.B. TESTS AND IMMUNIZATIONS" was "20 mm" (millimeters). Nurse's notes dated 6/4/11 at 5:00 p.m. indicated: "Res (resident) [up] in common area - noted R)FA (right forearm) PPD site [with] 20 mm raised soft area. Admin[istrator], D.O.N. & MD notified - rec'd (received) N/O (new order) per [name of physician] to place res in resp[iratory] isolation as precaution until CT (CAT scan) of chest complete [with] results to MD & call MD [with] PPD reading in AM - res placed in isolation." Physician's progress notes dated 6/5/11 at 11:35 a.m. indicated: "He has no pulmonary - except for some (observed) cough...Review of the CxR (chest x-ray) just prior to admission indicated the presence of a large mass - that had increased slightly of the (R) lung...In the 'findings' section of the report...'it is difficult to exclude active tuberculosis from this exam although it is felt to be less likely'...." Nurse's notes dated 6/5/11 at 12:00 p.m. indicated: "...Res had 10 mm on PPD. [Physician's name] here & checked on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PPD. [Physician] counseled Res about staying in room except to go outside to smoke. He stated he understood." Nurse's notes dated 6/6/11 at 8:00 a.m. indicated: "[Physician's name] called [with] orders for this resident as follows. Get Enhanced chest CT soon as possible today D/T (due to) mass and also positive PPD. Call this report to office for [Physician's name]." A laboratory test, dated 6/6/11, for "TB by Quantiferon Gold" indicated a result of "Positive." Nurse's notes dated 6/7/11 at 9:00 a.m. indicated: "Health dept notified." Nurse's notes dated 6/7/11 at 2:30 p.m. indicated: "Res did not return to facility. Res had appt (appointment) [with] pulmonologist...he did not show [up] - office called will reschedule if Res returns to facility." Nurse's notes dated 6/14/11 at 2:00 p.m. indicated: "Res re-admit to room...Alert & oriented X3...." A local hospital transfer sheet dated 6/14/11 indicated Resident #21 was admitted to that hospital on 6/11/11 and discharged on 6/12/11. While in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hospital, the resident had sputum testing done for tuberculosis and the testing was negative, but indicated "6 weeks required for final negative report." The transfer sheet dated 6/14/11 from the local hospital indicated the following medication orders for tuberculosis medications: rifampin 600 milligrams (mg) every day by mouth, INH 300 mg every day by mouth, ethambutal 400 mg (3) every day, and pyrazinamied 500 mg (e) every day by mouth, and "anti TB meds for at least 30 days but up to 30 days, check with health dept before stopping." Review of nurse's notes from 6/14/11 through 7/5/11 indicated Resident #21 would leave in his truck at times, and would sometimes sign himself out of the facility for leave of absence, and sometimes not sign himself out when he left. A policy and procedure for "ISOLATION PRECAUTIONS" was provided by the Administrator on 8/18/11 at 2:25 p.m. The policy included, but was not limited to: PURPOSE: to prevent cross-contamination between patients and hospital personnel. To confine and contain any infectious disease agent...POLICY...6. Respiratory			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Isolations (Droplet or Airborne)...Airborne precautions require a negative pressure room. All patients requiring respiratory isolation shall be placed in a private room...limit movement and transport of patient from the room to essential purposes only, if possible. [Negative] pressured rm (room) not available." During an interview on 8/18/11 at 2:10 p.m., the Administrator indicated Resident #21 did not want to wear a mask, he left against medical advice because he felt he was singled out, and he said he wanted to leave. She said he was not sent out immediately because he was under the advice of the attending physician, and the resident and staff wore masks. The Administrator also indicated the facility does not have a negative air flow room, and the facility refused to allow him back in the facility until he was not contagious. During interview with the Administrator on 8/18/2011 at 1:05 P.M., she stated, "We don't have a TB isolation policy and procedure that I can find." During interview with the Administrator at 2:00 P.M., on 8/18/2011, she stated, "I'm unable to locate a Respiratory Isolation Policy and Procedure." B. Review of the facility monthly infection control logs received from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director of Nursing on 8/17/2011 at 1:00 P.M., indicated the following: April 2011: 4 residents were listed with UTI [urinary tract infection] and 2 residents with pneumonia, with no precautionary measures for one of the residents with UTI, and all of the others had S = standard precautions. The area for "Nosocomial" "yes/no" was left blank for all of the residents. Only one showed a causative agent/culture results. There were no signatures. And, "reporting period" was left blank, as well as all of the information at the bottom of the page to use for tracking of infections was blank. One resident's room number was listed, the others were blank. Monthly infection control logs for May 2011, indicated 5 UTIs, 2 pneumonia, and 1 red eye treated with eye ointment. One case of pneumonia was treated with Rocephin IV; no treatment was indicated for the other pneumonia. There were no onset dates for 1 pneumonia and red eye infection, no precautionary measures for pneumonia, no room numbers, and no admit dates, and information at bottom of page for tracking was all blank. Monthly infection control log for June 2011, indicated 7 entries, 1 with admit date, 1 with no room number listed, 4 respiratory, 1 with causative agent culture			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	results indicates TB and treatment Cipro and no precautionary measures. None of the information at the bottom of the page was completed (all left blank). Monthly infection control logs for July 2011, indicated no admit dates or information at bottom of page filled out. There were 3 UTIs and 2 respiratory infections, all listed as standard precautions, with no causative agents listed. Monthly infection control logs for August 2011, indicated no admit dates, no causative agents, 4 out of 8 had no room number listed, 3 of 8 entries indicated yes to nosocomial infection, 4 indicated standard precautionary measures, and none of the information at the bottom of page was completed (all left blank). Review of Policy and Procedure for Monthly Infection Control Log provided by Charge Nurse/Social Services/Activities Director with an effective date of March 18,2009, indicated "Purpose: To ensure on-going system of surveillance of infections and to be reviewed by the CQI committee and medical director of the facility to identify areas of infection and problems and to control, plan, and detect epidemics, evaluate implementation of infection and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	control measures and to include to direct in-service education needs of the facility staff." "Procedure: Licensed nurses on the monthly infection control log to include resident's name and symptoms and or site of infection and the treatment initiated. The licensed nurse when obtaining an antibiotic should fill in the monthly infection control log at the time of symptoms or antibiotic ordered." 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(g) 3.1-18(i)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented in that residents had incomplete documentation on the medication administration records related to fasting blood sugars, intakes, and medications. This affected 2 of 8 residents reviewed for	F0514	F 514The director of nursing reviewed the current clinical records of resident # 7 and resident # 15, back to July 2011. All residents' current clinical records were reviewed and evaluated for complete and accurate documentation. Nurses were interviewed and educated individually, related to the findings	08/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	complete and accurate records in 8 sampled. (Residents #7 and 15) Findings include: 1. Resident #7's record was reviewed on 8/15/11 at 1:00 p.m. The record indicated resident #7 was admitted with diagnoses that included, but were not limited to, cerebral vascular disease with dementia, diabetes, iron deficiency anemia, high blood pressure, heart disease, and a peg tube (feeding tube). Physician's orders dated 7/11/11 indicated an order for Lantus insulin, 100 units per milliliter, inject 20 units subcutaneous twice a day. Medication administration records (MARS) dated 7/01/2011 through 7/31/11 indicated the following dates and times lacked documentation of the nurse's initial that would indicate the Lantus had been administered: - 7/18 at 8:00 p.m. - 7/23 at 8:00 p.m. - 7/25 at 8:00 p.m. Physician's orders dated 4/10/11 indicated orders for fasting blood sugar tests before meals and at bedtime. MARS dated 7/01/11 through 7/31/11 indicated the following dates and times lacked		noted in the report to investigate if services were provided as ordered. On August 24, 2011, All Licensed Nurses were in-serviced on accurately and complete documentation. Every charge nurse is responsible to document accurately and completely as facility policy and procedure directs through out their shift. The charge nurse is responsible to contact the previous nurse if lack of documentation is noted to investigate if services have been given and if not reason why they were not. The director of nursing will monitor complete and accurate documentation, no less than monthly. CQI will monitor clinical records, no less than quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of the nurse's initial to indicate the fasting blood sugar tests had been done, and the results of the tests: - 7/2 at 8:00 p.m. - 7/3 at 6:00 a.m. and 4:30 p.m. - 7/8 at 11:00 a.m. lacked the results of the test. - 7/14 at 11:00 a.m. - 7/15 at 11:00 a.m. - 7/16 at 8:00 p.m. - 7/23 at 8:00 p.m. Physician's orders dated 4/26/11 indicated an order to flush the peg tube with 200 milliliters of water five times a day. MARS dated 7/01/11 through 7/31/11 indicated the following dates and times were not initialed by the nurse to indicate the tube had been flushed: - 7/3 at 12:00 a.m. - 7/4 at 12:00 a.m. - 7/7 at Noon - 7/8 at 8:00 p.m. - 7/9 at noon and 12:00 a.m. - 7/10 at 12:00 a.m. - 7/11 at 12:00 a.m. - 7/17 at 4:00 p.m. and 8:00 p.m. - 7/24 at 12:00 a.m. Physician's orders dated 6/26/11 indicated an order to document intakes every shift. MARS dated 7/01/11 through 7/31/11 indicated the following dates and times the intakes were not documented:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 7/2 on the 10:00 p.m. to 6:00 a.m. shift - 7/3 on the 10:00 p.m. to 6:00 a.m. shift - 7/9 on the 10:00 p.m. to 6:00 a.m. shift - 7/10 on the 10:00 p.m. to 6:00 a.m. shift - 7/11 on the 6:00 a.m. to 2:00 p.m. shift - 7/24 on the 10:00 p.m. to 6:00 a.m. shift Physician's orders dated 4/26/11 indicated an order for Glucerna full strength at 55 milliliters per hour via the peg tube. MARS dated 7/01 through 7/31/11 indicated the following dates and times were not initialed by the nurse to indicated the Glucerna had been given: - 7/3 on the 10:00 p.m. to 6:00 a.m. shift - 7/10 on the 10:00 p.m. to 6:00 a.m. shift - 7/15 on the 2:00 p.m. to 10:00 p.m. shift 2. Resident # 15's clinical record was reviewed on 8-16-11 at 11:23 a.m. Review of the Medication Administration Record (MAR) indicated multiple documentation of administration omissions of medications and lack of documentation of withheld medications on the July 2011 MAR. The MAR for July 2011 indicated the following omissions of documentation: -Oxycontin 20 mg (milligrams) by mouth every 8 hours routine: 7-13-11. Review of the controlled medication log indicated this medication was not documented as signed out. Review of the nursing notes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Docusate Sodium 100 mg daily by mouth: 7-21-11. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Diovan 320 mg daily by mouth: 7-21-11. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Aspirin EC 325 mg daily by mouth: 7-21-11. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Ursodiol 300 mg twice daily with meals by mouth: 7-22-11 at 5:00 p.m. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Renvela 800 mg 3 tablets three times			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily with meals by mouth: 7-20-11 and 7-21-11 at 5:00 p.m. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Calcium Acetate 667 mg 2 capsules three times daily with meals by mouth: 7-20-11 and 7-21-11 at 5:30 p.m. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. The MAR for July 2011 indicated the following medications had been not given as indicated by the medication administering staff had circled their initials. However, documentation was not located to indicate the circumstances for why the medication was not given for the following medications: -Renvela 800 mg 3 tablets three times daily with meals by mouth: 7-20-11,7-21-11, 7-26-11, 7-27-11, and 7-29-11 at 8:00 a.m.. Review of the nursing notes did not indicate any documentation of the medication not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Calcium Acetate 667 mg 2 capsules three			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	times daily with meals by mouth: 7-20-11, 7-21-11, 7-26-11, and 7-27-11 at 7:30 a.m. Review of the nursing notes did not indicate any documentation of the medication being given or not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. -Ursodiol 300 mg twice daily with meals by mouth: 7-20-11 at 7:00 a.m. Review of the nursing notes did not indicate any documentation of the medication not being given. Review of the reverse side of the MAR did not indicate the medication had not been given. In interview with the Assistant Director of Nursing on 8-17-11 at 9:54 a.m., she indicated any doses of medications not given or refused should be documented on the back side of the MAR or in the nursing notes. The Administrator provided a policy entitled, "Specific Procedures for All Medications Policy," on 8-17-11 at 3:15 p.m. This policy was identified by the Administrator as being currently in use. The policy indicated, "...K. After administration document administration in the MAR or TAR [Treatment Administration Record]. L. If resident refuses medication, document refusal on MAR or TAR..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 00 B. WING	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-50(a)(1) 3.1-50(a)(2)			